Exhibit A7

d to		
[1500]		UNITED HEALTHCAREMETRAHEALTH
HEALTH INSURANCE CLAIM FORM		PO BOX 30555
		SALT LAKE CITY UT 84130
ASPROVED BY NATIONAL UNIFORM OLA MICOMMITTEE OF 03		
		PICA
MEDICARE MEDICAD TRECARE CHAMP	HEALTH PLATE EXILLYS -	ER 1a INSURED B : D NUMBER (For Program in Hem 1)
2 PATENTS NAME (Lots Nome, First Name, Middle Intell)		
	3 PAT ENT SENTH DATE SEX	4 INSURED'S NAVE (LEU NOTIC FOU NOTE VIGE 1915)
5 PATEVICE ADDRESS (No. 5702)	6 PATENT RELATIONSHIP TO ASSURED	7 INSURED S ACCRESS IN Street
	927 Spa X] C+ 1 C+4	Control and the second
G	B PATIENT STATUS	CITY
	Sing's Marraid Other	STATE
ZIP CODE TELEPHONE (THE . sto Area Copie)	1	ZP CODE TELEPHONE (DELIGIO Area Code)
	Employed Student Student	TELEPHONE (SELECTION AND COME)
8 ATHER INSURED NAVE O AN ENTE FOR Name, 1/ 10/8 (* 10)	10 IS PAY ENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP ON FECA MUNISER
	1	1304000
a OTHER INSTIRENT & POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Pravious)	a. INSUREO'S DATE OF BIRTH SEX
	YES X NO	123 80 YY M
D. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M FX	TEP X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	© OTHER ACC:DENT?	C INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X_NO	UNITED HEALTHCAREMETRAHEALTH
AETNA US HEALTHCARE	10d RESERVED FOR LOCAL USE	d is there another health benefit plan?
READ BACK OF FORM SEFORE COMPLETING	2 A CIGURA THE COURT	X YES NO If year, return to and complete tem 9 a-d.
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the underlighed physician or supplier for
to process that claim it also request payment of government benefits other below. SIGNATURE ON FILE	to myser or to the party who excepts accignment	sorvices described below
- BIGNED :	03/02/11	SIGNATURE ON FILE
14. DATE OF CLUMBERT: / ILLNESS (Fast symptom) OR 15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	1 SIGNED
PREGNANCY(LMP) TLUNESE	GIVE FIRST DATE SIM DO YY	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JANIS CORNWELL MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DO YY
17b.	NPI 1023006871	FROM DD YY MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGMARIS OR MATTIRE OF HILLIPPE ARTHUR		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate liems 1, 2, 2	3 or 4 to item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO
1	Ψ	
2.		23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(8) OF SERVICE B. C. D PROCED	DURES, SERVICES, OR SUPPLIES E.	F G I H
From To RACE OF (Explan	n Unicus: Cotumptarters) DIAGNOSIS	DAYS TENT ID HENDERING
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FEDERAL TAX 10 NUMBER SSN EIN 26 PATIENT'S AC	COUNT NO 27 ACCEPT ASSIGNMENTS	28. TOTAL CHARGE 29, AMOUNT PAID 30 BALANCE DUE
63100406		
63189406 X PAGDE000		33 BILLING PROVIDED INFO 4 PM . ()
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACE	ILITY LOCATION INFORMATION	
I. SIGNATURE OF PHYSICIAN OR SUPPLER INCLUDING DEGREES OR CREDENTIALS MATLOCK OF	BGYN ASSOC PA	903 4508704
1. SIGNATURE OF PHYSICIAN OR SUPPLER INCLUDING DEGREES OR CREDENTIALS (TOUCH yet after mixed a part thereof) APPLIED THE STATE INCLUDING THE STATE ARE MIXED A PART THE STATE OF THE STATE	BGYN ASSOC PA FIELD 200	PARAGON AMBULATORY PHYS SERV
I. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS DEGREES D	BGYN ASSOC PA FIELD 200 TX 76014	PARAGON AMBULATORY PHYS SERV 11700 PRESTON RD STE 660506
11. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR OFFEDENTIALS (ICCUT) what the claimers or it wiresees apply to this bird are midd or pain thereof () 187 STORMER OF THE PHYSICIAN OF THE PHYSICIAN OF THE PHYSICIAN OR SUPPLIES OR	BGYN ASSOC PA FIELD 200 TX 76014	PARAGON AMBULATORY PHYS SERV

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	877-842-7860 B	UNITED HEALIFICAREMETRAHEALIH
	1500	PO BOX 30555 SALT LAKE CITY UT 84130 E 1
1	HEALTH INSURANCE CLAIM FORM	8 1
-	APÉROVEO BY NATIONAL UNIFORM CLAIM COMMITTEE 08/08	PICA TTT
	1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER CHAMPUS (Madicare #) (Medicaid #) (Spansor's SSN) (Member 10H) (SSN or 1D) (SSN) (SSN)	19. INSURED'S LO, NUMBER (For Program in Hem 1)
		4. (NGURED'S NAME (Last Name, First Name, Middle Initial)
	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX M F	0
	5. PATIENT'S ADDRESS (No., Siree!) 6. PATIENT RELATIONSHIP YO INSURED	ZINSURED'S ADDRESS (No., Street)
7	CITY LISTATE, 8, PATIENT STATUS	ZIP CODE TELEPHONE (Include Area Code) 8
矛	Single Married Other	E 2
	ZIP CODE TELEPHONE (Include Area Code) [ZIP CODE TELEPHONE (Include Area Code)
	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	2P CODE TELEPHONE (Include Area Code) 11. INSURED'S POLICY GROUP OR PECA NUMBER 711.735 a. INSURED'S DATE OF BIRTH b. EMPLOYER'S NAME OR SCHOOL NAME
	a, OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	5. OTHER INSURED'S DATE OF SIRTH SEX 5. AUTO ACCIDENT? PLACE (SIEW)	B. EMPLOYER'S NAME OR SCHOOL NAME
	MM DD YES NO	A STATE OF THE STA
	« EMPLOYER'S NAME OR SCHOOL NAME C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OF PROGRAM NAME UNITED HEALTHCAREMETRAHEATTH
	d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE	G, IS THERE MOTHER HEALTH BENEFIT PLAN?
	DU DIVOS CONNETINO I BIGUINO TUIO CODI	VES NO # yes, return to end complete item 9 a-d, 13. INSURED'S OF AUT-KORIZED PERSON'S SIGNATURE I sutrorice
	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I suthorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to mysaif or to the party who accepts assignment below. SIGNATURE ON FILE	payment of medical benefits to the undersigned physician or supplier for services described below.
	SIGNED DATE	SIGNED Y
	14. BATE OR DUBRENT LILINESS (First symptom OR 1111) ESS 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. INJURY (Accident) ORILLINESS. ONE FIRST DATE MIDS ON PREGNANCY (LINES)	Tricks .
	17. NY 178. 178. 178. 178. NPI 1922000710	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES OF THE PROPERTY OF THE P
	19. SUPPLEMENTS FAXED TO CARRIER	20. DUYSIDE LAB? X \$ CHARGES
	21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Relate literes 1, 2, 5 or 4 to Item 24E by Line)	28. MEDICAID RESUBMISSION ORIGINAL REF. NO.
	V25 12 1.	23. PRIOR AUTHORIZATION NUMBER
Ţ		25, PRIOR AUTHORIZATION NOMBER
F.	24. A DATE(9) OF SERVICE B. C. D. PROCEDURES, SERVICES, OA SUPPLIES From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS MM DD VY MM DD VY SERVICE EMG CPT/HCPCS MÓDIFIER POINTER	F. G. N. I. J. RENDERING OF FROM OUR. PROVIDERING PROV
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	26. PERSONAL TENUMBER SON EIN STEAM PRODUCTION 29734CCET LASSIGNMENT?	88. TOTAL CHEESEN . OO 29. AMOUNT PAID 30. BALASSEGGE OO 5 888 5592666
	31. SIGNATURE OF PHYSICIAN OR SUPPLIER SASSACTED TOPOCACIONOS SECURITOR SIGNATURE DE CONTROL 3233	33.80 MARINGER PHISUPPORTS VCS 4347 W NW HWY 120 PMB 262
	(conflit that the statements on the reverse (1919 S SHILLCH 333 SANCE TRANSPORTED FOR THE PROPERTY OF THE PROP	DALLAS TX 75220
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